MARK S. BRIGHAM, D.O., INC.
195 Wadsworth Rd., Ste. 401
Wadsworth, OH 44281
330-336-8717 phone
330-335-0092 fax

AUTHORIZATON TO "OBTAIN" MEDICAL INFORMATION

This is to authorize all doctors and staff of Mark S. Brigham, D.O., Inc., to obtain, for observation and inspection, the following stated medical records pertaining to my treatment while a patient of:

Doctor: _____

Address: _____

_____

Fax#: _____ Phone #: _____

I understand that my records are protected under the Federal Privacy Act and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that the office supplying my records may charge me a fee for copies.

Patient Name: _____ ID#: _____DOB_____

Date(s) of Service: _____

Records: _____

_____

Address of Office to send records: **Mark S. Brigham, D.O., Inc.**
195 Wadsworth Rd., Suite 401
Wadsworth, OH 44281
Fax: 330-335-0092 Phone: 330-336-8717

PATIENT SIGNATURE: _____

TODAY'S DATE: _____

WITNESS SIGNATURE: _____

TODAY'S DATE: _____

MEDICAL RECORDS OFFICE USE ONLY

Completed Request: _____ By:_____
(Date) (Employee)

FAXED [ ] MAILED [ ] HAND DELIVERED [ ]